



The Cutting Edge: Understanding and Addressing Non Suicidal Self Injury (NSSI) in Adolescents and Young Adults

The Cornell Research Program on
Self-Injurious Behavior in Adolescents
and Young Adults (CRPSIB)

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What We'll Cover

- NSSI epidemiology
 - Form, prevalence and function
 - Comorbidity
 - Relationship to suicide
- Vectors for contagion
- Detection and intervention
- Resources and Q & A

Why participate?

- To review most recent information on self-injury basics
- To enhance understanding about why individuals self-injure, subjectively and physiologically
- To learn about common treatment approaches and productive strategies for detecting, intervening and preventing in schools and other community settings

NSSI Basics



Non~Suicidal Self~Injury (NSSI)

Deliberate, direct, and self~inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent.

International Society for the Study of Self-Injury (ISSI, 2007)

Taxonomy of Self-Injurious Behavior

- Major
 - Associated with psychosis (ex. amputation or castration)
- Stereotypic
 - Associated with other disabilities (ex. head banging)
- Common
 - Compulsive (ritualistic and rarely premeditated such as hair pulling or trichotillomania)
 - Episodic (every so often – no identification as someone who self-injures)
 - Repetitive (performed on a regular basis and with identification as someone who self-injures) (mild, moderate, severe)
- Note: There is also an “experimenter / follower” group who tends to begin as part of common / episodic group but who can become part of the repetitive group over time (Nock and Favazza, 2010)

Most Common Self-Injury Behaviors (17%~50%)

- Severely scratching or pinching skin with fingernails or other objects
- Cutting wrists, arms, legs, torso or other areas of the body
- Banging or punching objects to the point of bruising or bleeding
- Punching or banging oneself to the point of bruising or bleeding
- Biting to the point that bleeding occurs or marks remain on skin



Less Common Self-Injury Behaviors (8%~12%)

- Ripping or tearing skin
- Pulling out hair, eyelashes, or eyebrows with the overt intention of hurting oneself
- Intentionally preventing wounds from healing
- Burning wrists, hands, arms, legs, torso or other areas of the body
- Rubbing glass into skin or stuck sharp objects such as needles, pins, and staples into the skin



Infrequent Self-Injury Behaviors ($<4\%$)

- Engaging in fighting or other aggressive activities with the intention of getting hurt
- Trying to break bones
- Self-asphyxiation
- Salt and ice burns
- Ingesting caustic substance(s) or sharp objects
- Dripping acid onto the skin
- Mutilating genitals or rectum
- Breaking bones



How common is it?

- Among children (<11 years old)
 - Lifetime prevalence .8% among children with no known mental health difficulties (6% – 8% when other disorders present)
 - 7% – 25% start <11 in retrospective studies
- Among adolescents and young adults
 - Lifetime NSSI estimates range from 7% – 25.6% (up to 65% in clinical populations)
 - 75 – 80% of all report NSSI is repeat (25% single incident)
 - An estimated 6 – 10% are current repeat
- Among adults
 - Lifetime prevalence 5% – 8%



Who is at highest risk?

- Females may be at slightly higher risk, but no consensus
- Some studies show Caucasians at slightly higher risk
- Sexual minorities, particularly bisexual, at significantly higher risk (47% of bisexual women reported NSSI in 2 studies)
- Individuals with history of trauma/abuse
- Individuals high in emotion detection/generation but low in emotion regulation skill
- Individuals with history of emotion dysregulation or sensitivity

See Jacobson & Gould, 2007 and Rodham & Hawton, 2008 for reviews of NSSI in adolescents; Heath, Toste, Nedechewa, & Charlebois, 2008; Whitlock, Eckenrode, & Silverman, 2006; Whitlock, et al., in press for NSSI in college students.

Gender Differences

- Compared to males, females are more likely to report:
 - Scratching and cutting
 - Always injuring in private and injure episodically
 - Habituation and perceiving life interference
 - Seeking medical treatment for injuries
 - Seeking mental health treatment
- Compared to females, males are more likely to report:
 - Starting for social reasons or because drunk or high
 - Injuring in the presence of others, letting others cause injuries, or injure another as a part of a routine
 - Injuring while intoxicated (and reporting this as a factor when they hurt themselves more severely than intended)
 - Obsessive-compulsive disorder
 - Substance abuse



CoMorbidity

- NSSI is not a DSM IV classified disorder. It is one of the criteria for Borderline Personality Disorder (BPD) and has been associated in clinical samples with:
 - PTSD
 - Anxiety disorders
 - Depression
 - Disordered eating
 - Obsessive-compulsive disorder
 - Substance abuse
- Moderate association with non-psychiatric risk behaviors
 - Sexual risk taking
 - Alcohol use
 - Non-prescription medical drug use
- 44% of those reporting NSSI report no other DSM IV classifiable symptoms (Gollust SE, Eisenberg D, Golberstein E, 2008)
- Mentioned in DSM V, Section 6 as meriting additional research

NSSI Groups

- **Superficial (14.6%)**
 - Relatively low lifetime NSSI frequency
 - Use very few NSSI forms, superficial tissue damage (e.g., wound interference or scratching)
- **Battery / Light tissue damage (50.1%)**
 - Low NSSI lifetime frequency
 - Use several NSSI forms, moderate tissue damage (e.g., bruising and small punctures).
 - 64% of all self-injurious males in this group
 - Generally of shorter duration than other classes
- **Chronic / high severity (35.2%)**
 - High lifetime NSSI frequency
 - Use several NSSI forms, high tissue damage
 - Most likely of all groups to conform to the classic “cutter” stereotype (routines, habituation, hurt more than intended, & perceive life interference)

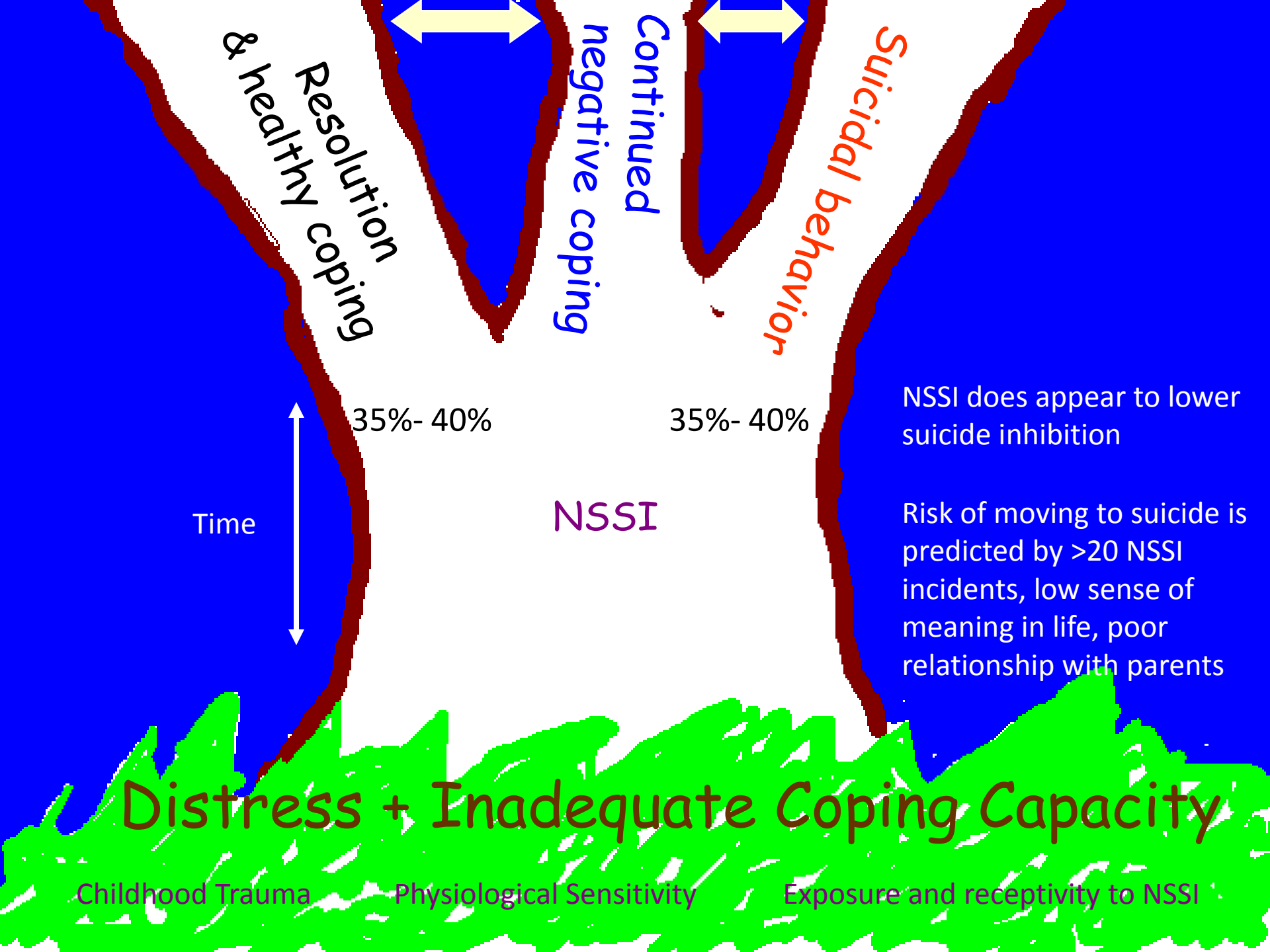
Other Characteristics

- 70% of individuals with repeat self-injury use >1 method
- Over 60% always injure in private, but 40% do not (likely younger in age)
- 15% - 20% have used drugs or alcohol when they self-injure
- 20% report episodic NSSI
- 21% indicated that they had injured themselves more severely than expected at least once; 6.2% report ever having seen a medical professional
- NSSI can become habitual with addiction features (in 25%-30% of all reported cases)

Is NSSI a suicide attempt?

- No
- NSSI is most often used as a means of soothing oneself not as a means of ending one's life
- Since NSSI and suicidality do indicate underlying distress it is important to assess whether self-injurious youth are also suicidal
- NSSI is best understood as a means of self-regulation and self-medication. It is typically intended to preserve and enhance rather than end life



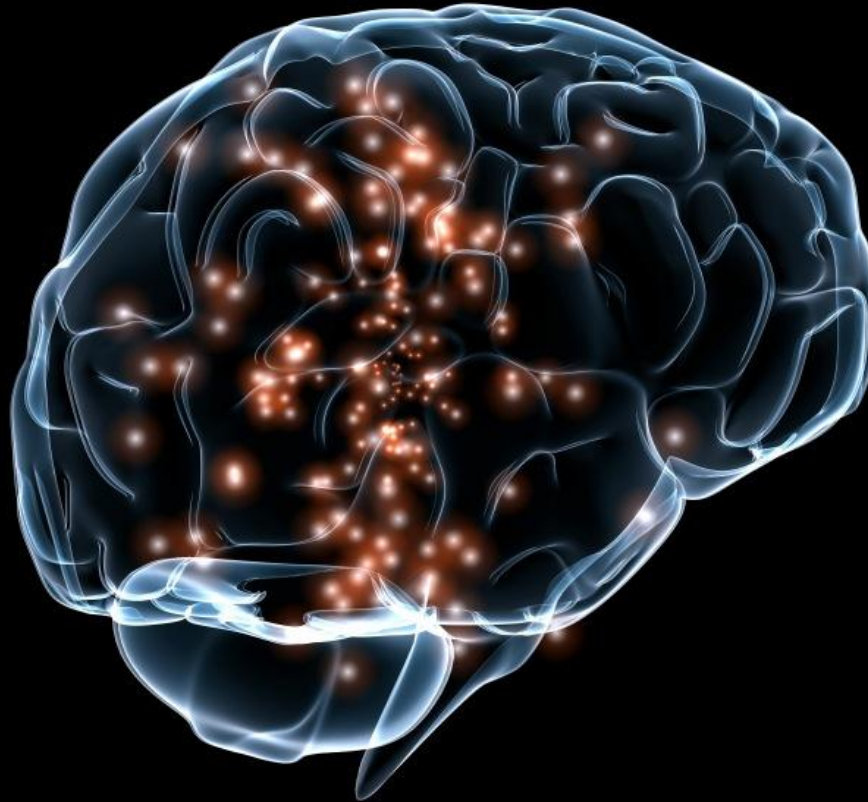


Why self-injure?

Described Function

- **Regulate negative affect or no affect**
 - To cope with uncomfortable feelings (50.6%)
 - To relieve stress or pressure (43.4%)
 - To deal with frustration (37.1%)
 - To change emotion into something physical (35.7%)
 - To deal with anger (25.2%)
 - To help me cry (11.1%)
 - To feel something (26.1%)
- **Self-control**
 - To exert control over oneself or life (19.6%)
- **Self-punishment**
 - To atone for sins (18.2%)
 - To express self-hatred (14.4%)
- **Addiction**
 - Uncontrollable urge (16.8%)
- **Self distraction**
 - To distract me from other problems or tasks (20.1%)
 - To create an excuse to avoid something else (4.2%)
- **Sensation seeking**
 - Because it feels good (15.7%)
 - To get a rush or surge of energy (11.2%)
- **Social communication / belonging**
 - In hopes that someone will notice (18.4%)
 - To shock or get back at someone (11.0%)
- **Self-connection and preservation**
 - So I don't hurt myself in other ways (5.7%)

How does self-injury help someone feel better?

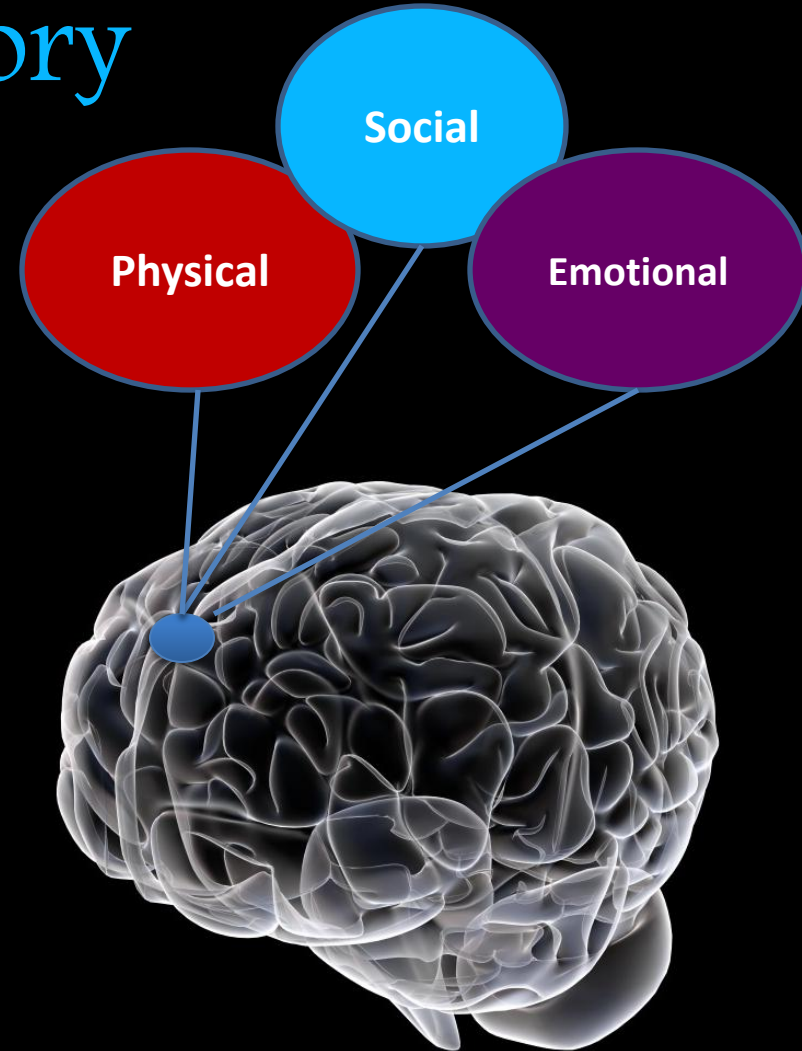


A neurological explanation

Based on a talk presented by J. Franklin, 2012 at the International Society for the Study of Self-Injury

Neural Reuse Theory

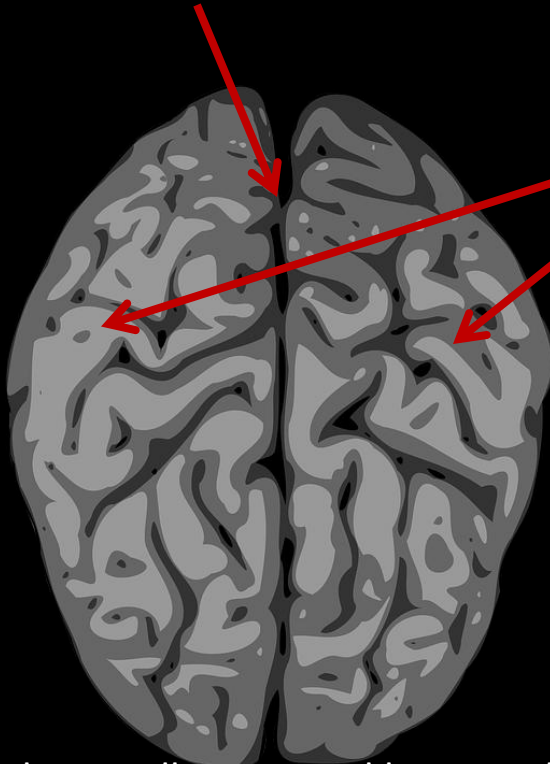
- Neural circuits established for one purpose become redeployed during evolution to serve additional purposes (Anderson, 2010)
- One neural circuit can serve multiple functions and these can be very general (e.g., core affect)



Based on a talk presented by J. Franklin, 2012 at the International Society for the Study of Self-Injury

Key Brain Players: ACC and AI

**Anterior
Cingulate
Cortex**



**Anterior
Insula**

- Leads to some odd interpretations and brain tricks:
- Holding a cup of warm coffee while meeting someone new tends to increase likelihood of describing that person as “warm” (Bargh et al., 2010)

Social and Physical Pain Overlap

- ACC/AI are pain perception areas and targeted for pain reduction by some medications (e.g., Tylenol)
- Holding hands also reduces AI/ACC activity and reduces both physical and emotional pain perception (Eisenberger et al., 2011)

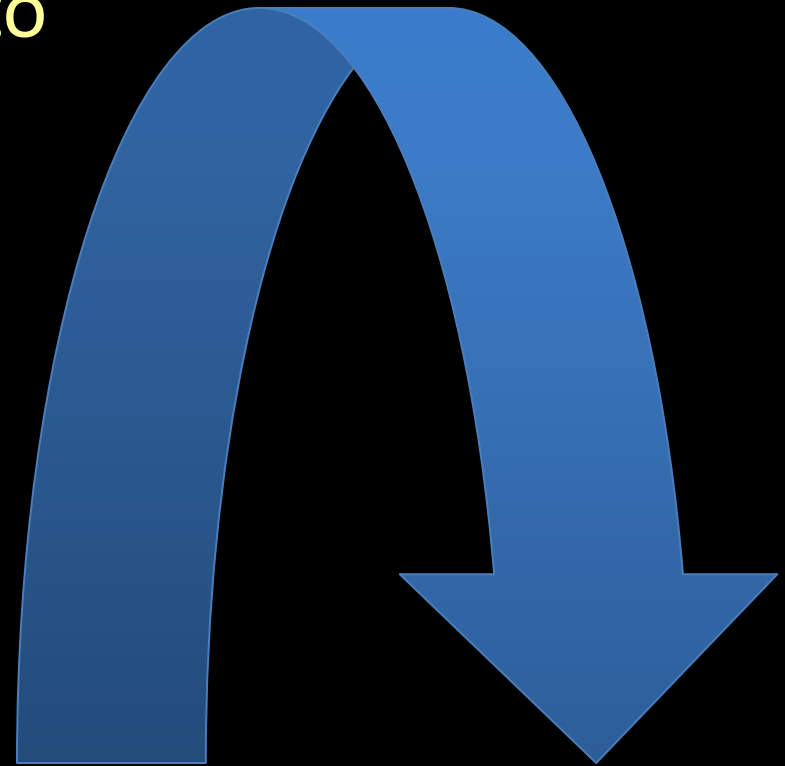


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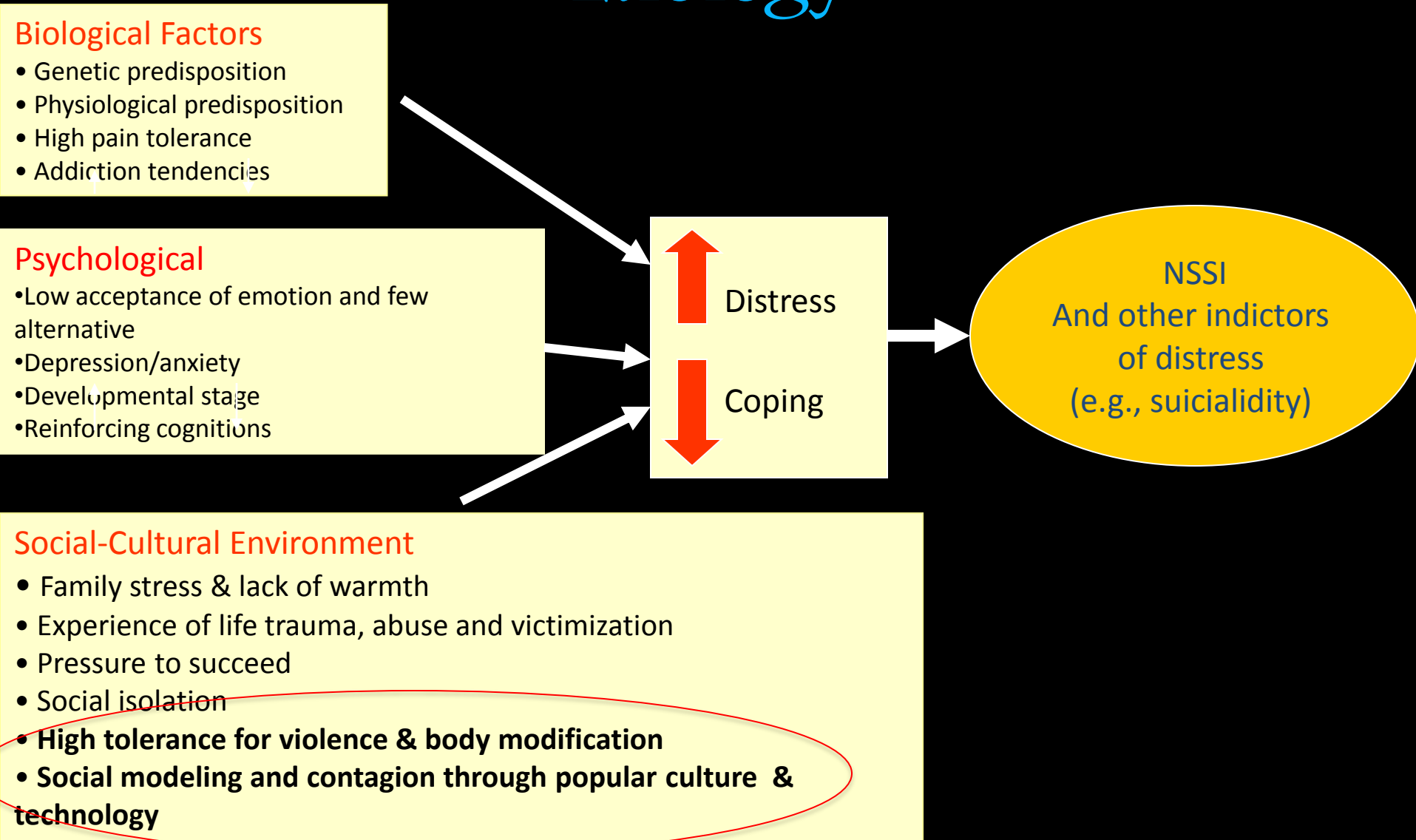
So.....

- Physical pain spills over into emotional/social pain
- Physical pain relief spills over into emotional/social pain relief

Small Decrease in Pain Intensity
=
Powerful Decrease in Pain Perception



Etiology





Things to Keep in Mind

- For most individuals NSSI emerges from developmentally normal impulses:
 - To feel better
 - To emotionally regulate
 - To self-integrate
 - To exercise agency
- Individuals who practice NSSI are often emotionally perceptive but struggle with regulating their perceptions and their responses
- NSSI is symbolically “agentic” – it reflects physically what the injurer wishes to do emotionally – namely to successfully endure and heal pain.

Is self-injury spreading?

- General consensus among college mental health providers, secondary school staff, researchers, and community-based health and youth professionals is yes.





Angelina Jolie

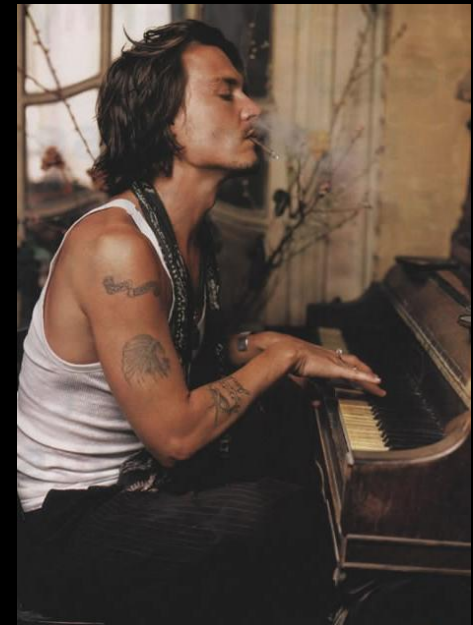
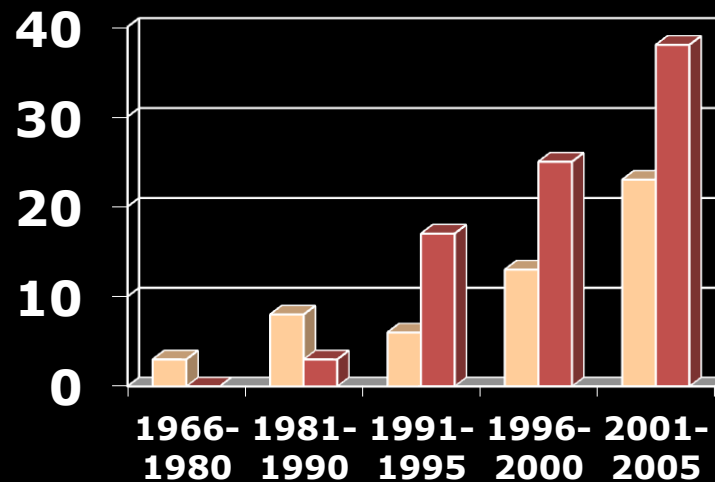
NSSI in the Media

Movies
Music
The Internet
TV shows

Magazines, Newspapers, Books

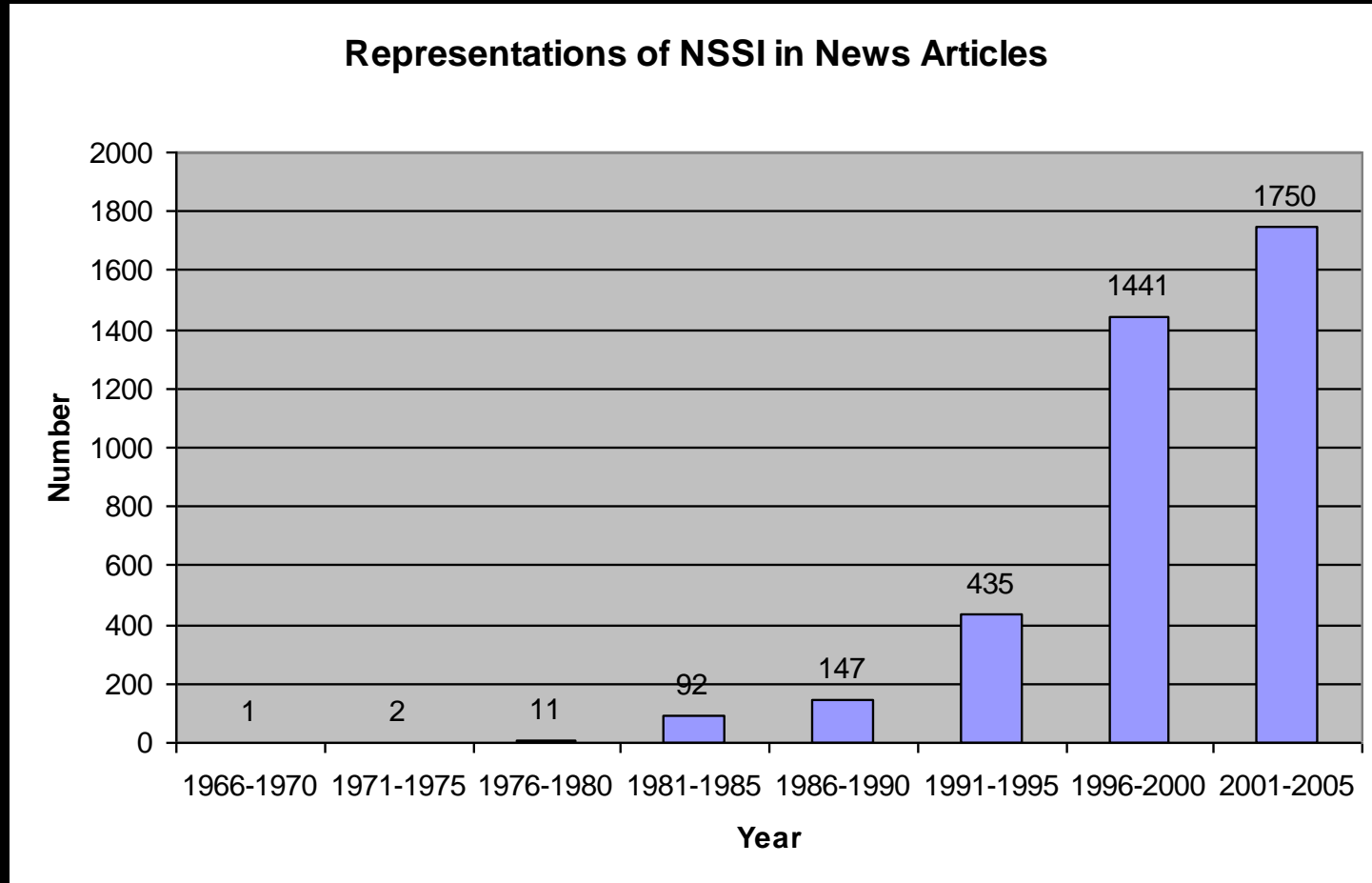


Princess Diana



Johnny Depp

NSSI~Related News Stories 1983~2004



(Whitlock, J.L., Purington, A., Gershkovich, M. , 2009)

NSSI Communities

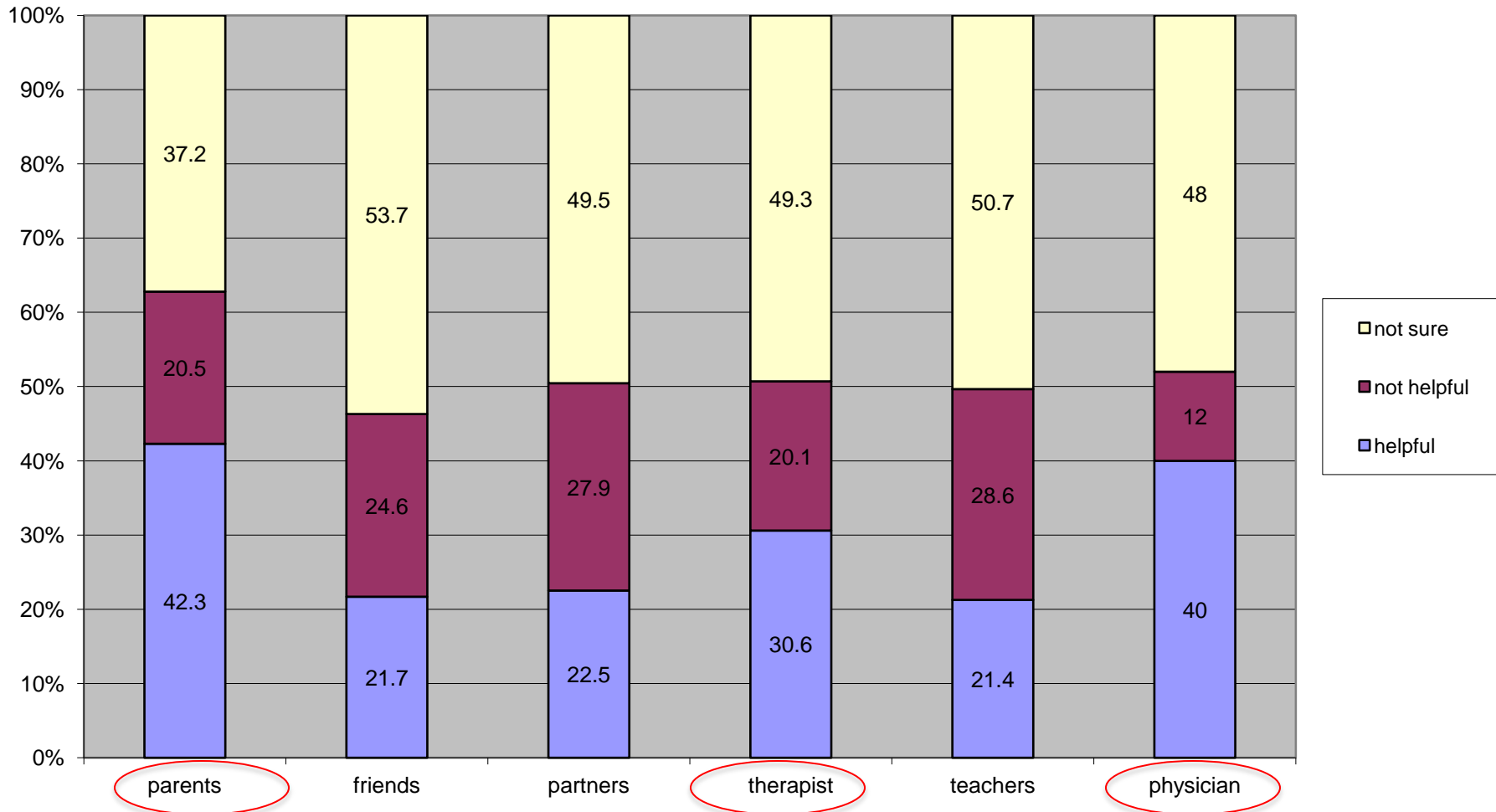
- Social groups are a source of learning about NSSI as a coping strategy. Middle school focus group response to “Where did you learn about self-injury?”:
 - The movie “13.”
 - Music, specifically songs by the group Evanescence and singer Sean Kingston.
 - Observing friends and relatives engaged in this behavior (usually older).
 - Saw injuring occur in a group.
 - Saw a friend “do it” and “thought that it might help.”
- Student reported that injury also occurs in the classroom, with students “passing around” a blade.
 - SI does happen in groups – with individuals injuring selves and others
 - There are sometimes a “selection” of blades offered for people to choose from during the group encounters
 - Injuring was cited as away to hurt someone else – specific injuries were “dedicated” to individuals who had wronged he/she who injured



Who knows?

- Just over half of individuals with self-injury experience in 2 studies sought and received therapy; 52% - 70% found it helpful
- Of those who received therapy for any reason in one study between 60%-80% did NOT discuss NSSI history or status
- The majority of individuals who believe someone suspects wish to talk about it with the individual who may know.

Points of Intervention: Who knows and how helpful was it?



Assessment and Intervention: Community and Family Settings

Detection

- Fresh cuts, bruises, burns or other physical marks of bodily damage
- Unexplained or clustered scars or marks
- Parental reports of blood in the sink/shower/tub
- Frequent bandages
- Odd/unexplained paraphernalia (e.g., razor blades or other cutting implements)
- Constant use of wrist bands or bracelets
- Inappropriate dress for season
- Unwillingness to participate in events that require less body coverage (e.g., swimming)
- Association with “goth” or “emo” subgroups



Responding

- Respond non-judgmentally, immediately and directly
 - Show “respectful curiosity”
 - Avoid shock or emotional displays
 - Don’t minimize
 - Assure rapid attention and assessment (suicide assessment indicated)
- Examples of respectfully curious questions:
 - How long have you been hurting yourself for?
 - Where on your body do you typically hurt yourself?
 - How does it help you?
 - When you resist the temptation to hurt yourself, what do you tell yourself or do that works?

Intervention: Respond, Assess, Engage, Educate, Refer

- Respond
 - Use respectful curiosity
 - Avoid shock or emotional displays
 - Don't minimize
- Assess
 - Immediate danger
 - General severity
 - Suicide risk
 - Risk of contagion
 - NSSI prevalence in student population
- Engage
 - Self-injurious student and supportive peers in directly addressing issue and underlying causes
 - Point people on staff or in community with expertise or knowledge in this area
 - Self-injurious student family if NSSI is frequent and/or of high lethality quality or if school protocol warrants parental notification
- Educate
 - Staff regarding signs, symptoms and appropriate response strategies
 - Yourself (or key staff point people) about local resources – therapeutic and educational
 - Self-injurious students about risk for contagion and the importance of not inadvertently a behavior that could hurt a friend
 - All students about symptoms of distress (not just NSSI) in self and others and positive strategies for coping with stress
- Refer
 - Self-injurious student and family to community-based therapist as needed

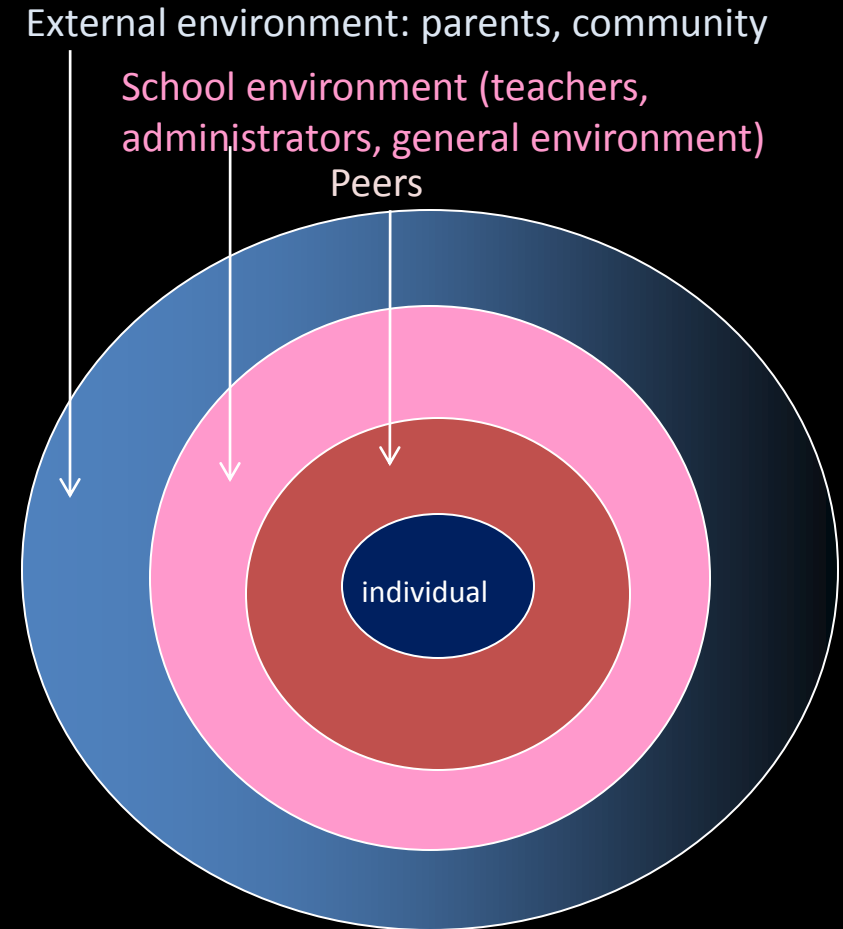
See

<http://crpsib.com/userfiles/NSSI-schools.pdf> for suggested school protocol



Focus on Prevention

- DO NOT provide broad NSSI education to students; DO provide this to staff
- Enhance:
 - Awareness of signs of global psychological distress, including but not limited to NSSI among all social ecologies
 - Capacity for emotion regulation and intelligence
 - Perceived social connectedness (particularly with parents and peers)
 - Capacity for reframing negative thoughts and narratives



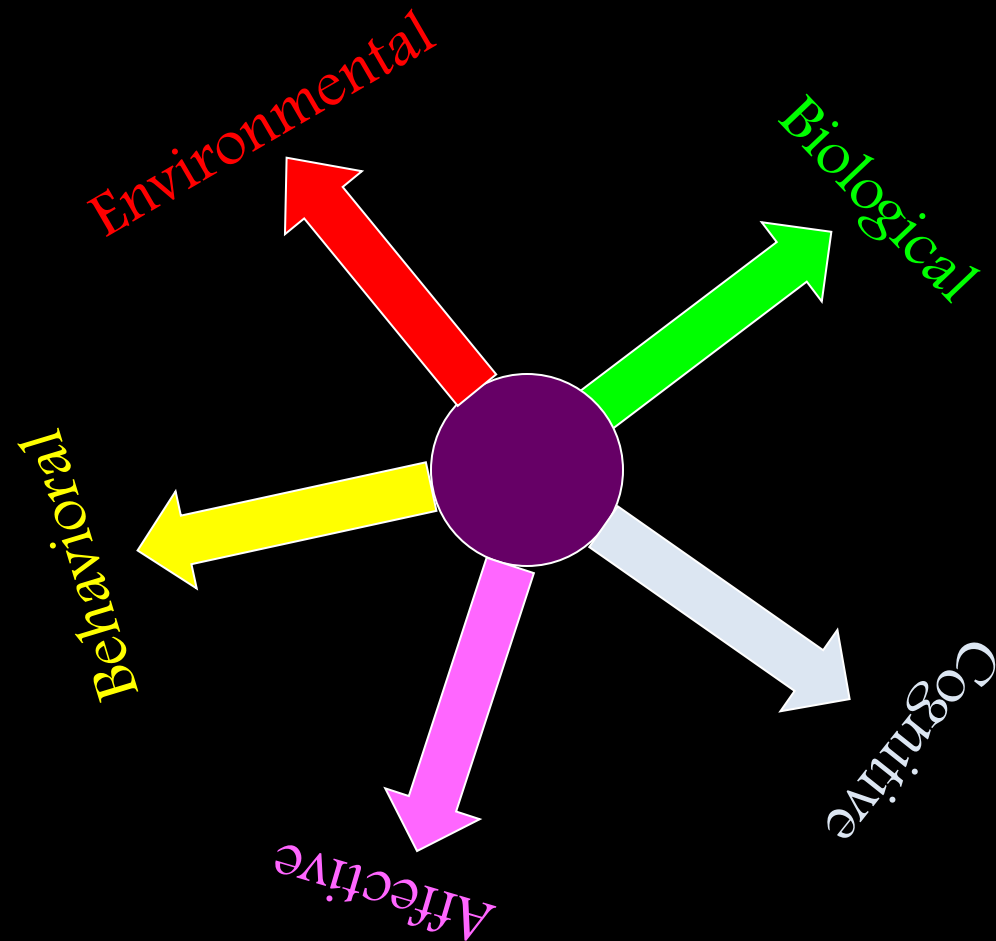
Assessment and Intervention: Therapeutic Settings

Typical NSSI Treatments

- **Common and promising approaches include:**
 - Dialectical Behavioral Therapy (DBT)
 - Cognitive Behavioral Therapy (CBT)
 - Acceptance-based emotion regulation (such as Acceptance & Commitment Therapy)
 - Ecological and strength-based approaches (such as those advocated by Matthew Selekman)
 - Problem Solving Therapy
 - Narrative Therapy
 - Sound Therapy
 - Pharmacological (typically SSRI's)

Muehlenkamp, J. J- Empirically Supported Treatments and General Therapy Guidelines for Non-Suicidal Self-Injury. *Journal of Mental Health Counseling*, 28, 2, 166.

The Biopsychosocial Model of Assessment for Documenting Antecedents, Behavior, Consequences



Special thanks to Dr. Barent Walsh for allowing me to adapt his model. See his forthcoming book, "Treating Self-Injury" for more detailed information

Behavioral Assessment: History and Details of Current SI

- Age of onset
- Form
- Function
- Wounds per episode
- Frequency of episode
- Episode duration
- Body areas involved
- Extent of physical damage
- Other forms of self-harm
- Tools / implements used
- Wound patterns and meaning
- Physical
- Social context

Self-Injury Log

Category	Mon	Tues	Wed	Thu	Fri	Sat	Sun
# of wounds							
Episode Start time							
Episode end time							
Extent of physical damage (length, width, sutures?)							
Body areas							
Pattern to wounds?							
Use of tool (implement)							
Trigger							
Reason (function)							
Pattern to wounds?							
Room or place							
Alone or with others?							

Be sure to a) ask about omissions and b) have clients place a “0” in boxes where no injury occurred – this is good positive reinforcement; see Dr. Barent Walsh’s forthcoming book, “Treating Self-Injury”

Positive Trigger Log

Date	What I did	My parents / siblings	Friends	Others involved	How it specifically helped

From Matthew Selekman's book, "The Adolescent and Young Adult Self-Harming Treatment Manual"
(2009)

My Epiphany Journal

Date	My Epiphany	Sparked by	Wisdom Gained	Applied to

From Matthew Selekman's book, "The Adolescent and Young Adult Self-Harming Treatment Manual"
(2009)

Notes on Therapeutic Assessment

- Be especially attentive to:
 - Extent of physical damage and body area affected
 - Idiosyncratic details about the self-injury, such as number of wounds, patterns or symbols, use of a tool, physical location
 - Recurrent environmental, cognitive, affective, and behavioral antecedents to the self-injury
 - Consequences of the self-injury, such as emotional relief
 - Communicative functions and social reinforcers in the environment (including internet communities)
 - Subjective meaning and function
 - Role of internet and off line communities in reinforcement and/or cessation support
 - Parents and proximal others are allies – engage them as collaboratively as possible

Adapted from Dr. Barent Walsh's forthcoming book, "Treating Self-Injury"

Self-injurers seek what we all seek: an ordered life, spiritual peace – maybe even salvation – and a healthy mind in a healthy body. Their desperate methods are upsetting to those of us who try to achieve those goals in a more tranquil manner, but the methods rest firmly on the dimly perceived bedrock of the human experience.

(Favazza, pp.322-232: Bodies Under Siege)

“Recovery is a long hike,
but do it anyway: The
view from the top is
amazing.”

*self-injury message
board post*



Thank You! and Resources

- **Websites:**
 - Cornell research program on self-injury and recovery: www.selfinjury.bctr.cornell.edu
 - S.A.F.E. Alternatives: <http://www.selfinjury.com/index.html>
 - The National Self-Harm Network (UK): <http://www.selfharm.org.uk/default.aspa>
 - The American Self-Harm Information Clearinghouse (ASHIC): <http://www.selfinjury.org/indexnet.html>
 - Resources for addressing mental health issues in schools: <http://smhp.psych.ucla.edu/>
 - Heart math: <http://www.heartmath.org/about-us/overview.html>
 - Collaborative for academic, social and emotional learning <http://www.casel.org>
- **Books & articles:**
 - All books by Barent Walsh and Matthew Selekman
 - Conterio, K., & Lader, W. (1998). Bodily harm: The breakthrough treatment program for self-injurers. New York: Hyperion Press
 - Whitlock, J.L., Lader, W., Conterio, K. (2007). The internet and self-injury: What psychotherapists should know. Journal of Clinical Psychology/In Session 63: 1135-1143. (available at www.crpsib.com)

